CRP-QA (FRM 102)
Revised: 6-27-2005

REPORT OF SUSPECTED MALTREATMENT

CHILDREN'S REVIEW PROGRAM (CRP)

FAX TO: *COUNTY OF INCIDENT, CHILD'S SSW, & REGIONAL CRP LIAISON*

(Please Print. Use One Form for Each Child Involved.)

Report Date: _____ County of Incident: _____ Incident Date(s): _____

1.

Child's Name (One (1) form per child)	DOB	Age	Sex	Race

2.

Child's Current Caretaker		Child's Current Address		
City	**State**	**County**	**Zip**	**Phone**

3. What is the child reporting? (Check all that apply)
☐ Physical Abuse ☐ Neglect ☐ Sexual Abuse ☐ Other: _____

4. Describe the alleged maltreatment reported by the child. (Attach Appendix A/B, if applicable)

5.

Alleged Perpetrator(s) (If the same as "2" above, write "SAA.")	Relationship	Agency and Address	Phone

6.

Interviewer's/Reporter's Name & Title	Phone	E-Mail

DCBS RESPONSE TO CRP FROM COUNTY OF INCIDENT

Per SOP 7E.2.7 ,DCBS has 10 working days to respond to this report. Responses will be sent to the attention of the Children's Review Program – Quality Assurance Unit, P.O. Box 13520, Lexington, KY 40583-3520. Fax (859) 225-3605 & Phone (859) 455-7452.

☐ Investigation will be conducted
☐ Investigation will **not** be conducted
☐ FINSA will be conducted
☐ FINSA will **not** be conducted

State Reason(s) for not conducting investigation or FINSA: _____

Name & Title of DCBS Responding Staff	Phone	E-Mail